ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Solicitor with Williamsons Solicitors for and on behalf of [redacted]** **2. [redacted], Solicitor with Berrymans Lace Mawer LLP for and on behalf of St Armands Court Residential Care Home in Garforth, Near Leeds** **3. [redacted] Solicitor with Hempsons Solicitors for and on behalf of Leeds Community Healthcare NHS Trust** **4. [redacted] Solicitor with RadcliffesleBrasseur LLP for and on behalf of [redacted] and [redacted] of the Moorfield House Surgery in Garforth Near Leeds** **5. [redacted] Solicitor with Leeds City Council Legal Services** **6. [redacted], NICE, 10 Spring Gardens, London** **7. His Honour Judge Peter Thornton Q.C., Chief Coroner for England and Wales**
1	**CORONER** I am Melanie J Williamson, Assistant Coroner, for the Coroner area of West Yorkshire (Eastern District)
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. [redacted]
3	**INVESTIGATION and INQUEST** On 19 July 2012 I commenced an investigation into the death of Mrs Gladys Smith aged 88 years. The investigation concluded at the end of the inquest on 10 October 2014. The Conclusion of the inquest was a Narrative Conclusion, a copy of which is annexed hereto.
4	**CIRCUMSTANCES OF THE DEATH** Please see attached Narrative Conclusion
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **(1) THE CARE HOME** (a) Advice and instruction given to Care Home staff as to the turning and repositioning of Mrs Smith was not followed and repositioning charts were not

completed. In the circumstances, all Care Home staff should ensure that all advice and instruction given by medical practitioners, that is to say by General Practitioners and District Nurses, in relation to residents is appropriately implemented and that turning/repositioning charts are completed;

(b) None of the bruises sustained by Mrs Smith, in particular the one which was noticed on the 25 May 2012, were body mapped by Care Home staff. In the circumstances, staff should ensure that all bruises sustained by residents are carefully body mapped at the first available opportunity;

(c) On or around 25 May 2012 bruising on the left side of Mrs Smith's bottom cheek was noted by Care Home staff together with a blister. However, District Nurse attendance in respect of an open area on Mrs Smith's bottom on her left side took place 7 (seven) days later on 11 June 2012. In the circumstances, Care Home staff should ensure appropriate medical advice is sought at the first available opportunity upon noticing a bruise to a resident following an apparent impact injury;

(d) Falls assessments in respect of Mrs Smith whilst a resident at the Care Home were not regularly undertaken and no consideration was at any time given by Care Home staff as to the most appropriate location for Mrs Smith's room within the Care Home. In the circumstances, falls assessments should be regularly undertaken in respect of all residents and regular consideration should be given as to the appropriate location of residents' rooms within the Care Home;

(e) Between January and June 2012 Mrs Smith lost a total of 28lbs in weight. Mrs Smith's weight was neither regularly monitored nor regularly and fully recorded. In the circumstances, Care Home staff should ensure that there is regular monitoring and appropriate recording of residents' weights';

(f) Despite the aforesaid weight loss experienced by Mrs Smith, at no time was a nutrition chart implemented in order to monitor Mrs Smith's nutritional intake. Moreover, medical advice in relation to Mrs Smith's weight loss was only sought a number of weeks after the commencement of the said weight loss. In the circumstances, Care Home staff should ensure nutrition charts are completed in respect of any resident whose weight falls significantly and should ensure appropriate medical advice is sought at the first available opportunity following such a fall in weight;

(g) Mrs Smith suffered from vascular dementia and had done so since the commencement of her residency at the Care Home. A number of other residents suffer from dementia. Care Assistants at the said Care Home have little or no knowledge of dementia and, consequently, how to care for residents suffering from such a condition. In the circumstances, all Care Home staff should undergo more indepth training in relation to dementia;

(h) Care Home staff do not proactively enquire of medical practitioners as to how to care for residents with certain medical conditions – for example, hiatus hernias, dementia. In the circumstances, Care Home staff should ensure proactive enquiries are made of relevant medical practitioners at the earliest opportunity as to the appropriate care for residents suffering from recognised medical conditions.

(2) LEEDS COMMUNITY HEALTHCARE NHS TRUST

(a) Members of the District Nursing Team who attended upon Mrs smith did not, upon each visit, fully record and document the dimensions and presenting features of the wound. In the circumstances, the Trust should ensure District Nurses do record and document all bruises and/or wounds, in particular the dimensions of the same together with a detailed description as to all presenting features;

(b) Mrs Smith was referred to the Tissue Viability Nurse Service on or around 25 June 2012, some 12 days after a referral ought to have been made according to expert evidence adduced in the course of the Inquest. In the circumstances, the Trust should ensure District Nurses make referrals to the Tissue Viability Nurse Service timeously;

(c) The Trusts Clinical Guidelines for Wound Management in Adults and Children omits to provide guidance as to when District Nurses should refer patients to the Tissue Viability Nurse Service. In the circumstances, the Trust should amend

	the said Clinical Guidelines in order to provide comprehensive guidance as to when such a referral to the said Service should be made **(3) NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE** (a) There are no NICE guidelines which provide any comprehensive guidance to Medical Practitioners in relation to the prevention and treatment of wounds and ulcers caused by impact injuries. Clinical Guideline 29 – The prevention and treatment of pressure ulcers, does not give guidance in respect of wounds/ulcers caused by impact injuries. In the circumstances there should be national guidelines which deal with such
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 January 2015, I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] and to NICE. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**17 November 2014** **Melanie J Williamson**